

***Exhibit H***

Metropolitan Life Insurance Company  
485-F US Highway 1 South, Iselin, NJ 08830



Jean Lin  
38 Daisy  
Irvine CA 92618

RE: Insured	Bang C. Lin
Policy Number	204 126 416 ET
State	California
Company	MetLife Insurance Company

Dear Mrs. Lin,

Your claim for the death benefit under the above referenced policy has been referred to my attention for reply, as I have the responsibility for the future handling of this case.

For your better understanding of our position, I am also enclosing a copy of the Application for Individual and Multi-Life Life Insurance for policy number 204 126 416 ET. I would like to respectfully point to the responses given by your husband to Question 22(a) and 22(c) in Part I; and Question 5(d), 6, 8(a), and 8(b) in Part II of the application. It was in reliance of these responses, which he agreed to be both true and complete, that the application for insurance was approved and policy issued.

The policy was issued on September 6, 2004 with a face amount of \$1,000,000. The policy is a 15-Year Term Plan of Insurance with Disability Waiver of Premium Rider. The policy contains the standard Incontestability provision referred to in our previous correspondence to you from Mary Stewart, Director dated February 5, 2007.

Since your husband's claim for Disability Waiver of Premium benefit commenced on November 29, 2005 and his unfortunate death on August 11, 2006 occurred within the contestable period, we conduct our usual inquiries.

These inquiries when concluded revealed that your husband was seen by Dr. Sam Kam from September 5, 1998 to August 7, 2004 for a history of Hepatitis B Virus (HBV) and treatment with interferon for the condition. There was also an Abdominal Ultrasound performed on March 27, 2004 at the Diagnostic Medical Group of Southern California, which indicated a history of Chronic Hepatitis B.

If we had been aware of this information, which was material from an underwriting perspective, the policy would not have been issued as applied for. As a result of this, we have considered the policy void and offered to refund all premiums paid to date with interest.

In closing, I have again thoroughly reviewed this matter and can find no basis for a change in our decision. If after reviewing the facts of this letter you decide to accept our offer of the premium refund please contact our office at 732-326-7306.

You may also have this matter reviewed by the California Insurance Department, Claims Service Bureau, 11<sup>th</sup> Floor, 300 South Spring Street, Los Angeles, California 90013. Their telephone number is 1-800-927-4357.

We are sorry that the circumstances compel us to make this unfavorable decision. While it might not be necessary to do so, it is customary to reserve all rights and defenses available to MetLife in the event of litigation. Therefore, this letter is written without waiver of, or prejudice to, any of MetLife's rights or defenses in the event of litigation.

Sincerely,

A handwritten signature in black ink that reads "Regina Solomon-Stowe". The signature is written in a cursive, flowing style.

Regina Solomon-Stowe  
Sr. Technical Claims Advisor  
CEC – Life Claims and Investigations

May 4, 2007

Encl.

# Application for Individual and Multi-Life Life Insurance

Metropolitan Life Insurance Company  
One Madison Avenue  
New York, NY 10010-3690

New England Life Insurance Company  
501 Boylston Street  
Boston, MA 02116-3700

General American Life Insurance Company  
700 Market Street  
St. Louis, MO 63101

MetLife Investors USA Insurance Company  
222 Delaware Ave, Suite 900  
P.O. Box 25130  
Wilmington, DE 19899

MetLife Investors Insurance Company  
700 Market Street  
St. Louis, MO 63101

**BELOW ARE INSURANCE FRAUD WARNING STATEMENTS THAT APPLY TO RESIDENTS OF SPECIFIC STATES. PLEASE READ IF THE STATE IN WHICH THE OWNER RESIDES IS LISTED.**

**Arkansas, Kentucky, Louisiana, New Mexico, Ohio, Oklahoma, Pennsylvania**

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

**Colorado**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of life insurance and civil damages. It is also unlawful for any insurance company or agent of an insurance company to knowingly provide false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with respect to a settlement or award from insurance proceeds. Such acts shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

**Washington D.C., Maine, Tennessee, Virginia**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

**Florida**

Any person who knowingly and with the intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**New Jersey**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.



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**Part I**

Company Use Only (Policy Numbers/Billing/MSA Number)

☒ Metropolitan Life Insurance Company☐ New England Life Insurance Company☐ General American Life Insurance Company☐ MetLife Investors USA Insurance Company☐ MetLife Investors Insurance Company

The Company indicated above is referred to as "the Company".

**1. Proposed Insured #1: Life 1**

Name: First, Middle, Last <b>BANG LIN</b>	Sex <b>M</b>	DOB Mo./Day/Yr. <b>8/6/69</b>	State/Country of Birth <b>TAIWAN</b>	Social Security Number <b>085-66-4606</b>
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**a) Current Residence Address and Phone Number:**

**7 GREEN HOLLOW, IRVINE, CA 92620**  
 (Street) (City) (State) (Zip)  
 (714) 774-9029 (949) 756-2222 Best time and place to call: **after 10 am**  
 (Home Phone) (Work Phone) ☒ a.m. ☐ Home ☐ p.m. ☒ Work

E-Mail Address:

**b) Driver's License Number and State of Issue:** **A 9644172 exp. 8/6/08****c) Employer's Name:** **Uni Micro****d) Occupation & Duties:** **President****e) Earned Annual Income:** \$ **150,000-** **Net Worth:** \$ **2,500,000-****f) Are you actively at work?** ☒ Yes ☐ No (If No, provide details)**2. Proposed Insured #2: Life 2 or Spouse/Covered Insured/Applicant's Waiver of Premium Benefit (For multiple persons under a Covered Insured rider, complete Other Insureds Supplement for additional persons.)**

Name: First, Middle, Last	Sex	DOB Mo./Day/Yr.	State/Country of Birth	Social Security Number	Relationship to Proposed Insured #1

**a) Current Residence Address and Phone Number (if different than Proposed Insured #1):**

(Street) (City) (State) (Zip)  
 ( ) ( ) Best time and place to call: ☐ a.m. ☐ Home  
 (Home Phone) (Work Phone) ☐ p.m. ☐ Work

E-Mail Address:

**b) Driver's License Number and State of Issue:****c) Employer's Name:****d) Occupation & Duties:****e) Earned Annual Income:** \$ **Net Worth:** \$**f) Are you actively at work?** ☐ Yes ☐ No (If No, provide details)

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3. Existing or applied for insurance, including any term riders or annuities: (If additional space is needed, provide details in the Supplemental Information section. If any existing insurance, complete state replacement forms as necessary.) If no existing or applied for insurance or annuity, check here. ☐ [Type: Life (L), Disability (D), Health (H), Annuity (A)]

Proposed Insured	Company	Type (L,D,H,A)	Amount	Year of Issue	Accidental Death Amount	
<i>Inwood</i>	<i>MetLife</i>	<i>L</i>	<i>500K</i>	<i>99</i>	<i>500,000 -</i>	<input type="checkbox"/> Yes
						<input type="checkbox"/> Yes
						<input type="checkbox"/> Yes
						<input type="checkbox"/> Yes

4. In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? (If Yes, complete the Replacement Questionnaire and Disclosure and any applicable replacement forms.) ☐ Yes ☒ No

5. Indicate Plan and Face Amount: ☐ list below or ☐ complete Product Supplement.

- a) Type of Insurance: ☒ Individual Life ☐ Survivorship/Joint Life  
☐ Group Conversion (For MetLife only.) (Complete Product Supplement.) ☐ Qualified Plan (Employee Group Number \_\_\_\_\_)

- b) Plan: *15 years Term* c) Face Amount: \$ *1,000,000 -*

Complete for Universal Life/Variable Life Products. (For Variable Life, also complete Variable Life Supplement.)

- d) Planned Premium (modal): Year 1: \$ \_\_\_\_\_ Excess/Lump Sum: \$ \_\_\_\_\_  
 Renewal (if applicable): \$ \_\_\_\_\_ Planned Annual Unscheduled Payment (if applicable): \$ \_\_\_\_\_

- e) Definition of Life Insurance Test (If choice is available under policy applied for.):

- ☐ Guideline Premium Test ☐ Cash Value Accumulation Test

- f) Death Benefit Option/Contract Type: \_\_\_\_\_

- g) Guarantee to Age: \_\_\_\_\_ or ☐ 5 Years (for MetLife Variable only.)

- h) Optional Benefits/Riders/Dividend Option: ☐ list below or ☐ complete Product Supplement.

<i>disability waiver</i>	

- i) Special Requests/Other: list below

<i>\$72 / month</i>

- j) Do you request an alternate/additional policy (if available)? ☐ Yes ☐ No  
 (If Yes, provide full details in Supplemental Information section and include signed and dated Illustration for each policy requested.)

## 6. MODE OF PAYMENT

- a) Mode of Payment: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☒ Bank Draft  
☐ Special Accounts ☐ Other \_\_\_\_\_

(Additional details/existing/new account numbers, etc.): \_\_\_\_\_

- b) Amount collected with application \$ *72* must equal at least one monthly premium.

## 7. SOURCE OF PAYMENT (Check all that apply:)

- ☐ Earned Income ☐ Money Market Fund ☐ Certificate of Deposit  
☐ Rollover/Transfer of Assets ☒ Savings ☐ Loan ☐ Other \_\_\_\_\_  
☐ Mutual Fund/Brokerage Account ☐ Use of values in another Life Insurance/Annuity Contract



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8. What is the purpose of this insurance? (Check all that apply):
- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Estate Planning | <input checked="" type="checkbox"/> Mortgage Protection | <input type="checkbox"/> Retirement Supplement | <input type="checkbox"/> Business Planning |
| <input type="checkbox"/> Final Expenses  | <input type="checkbox"/> Charitable Giving              | <input type="checkbox"/> Education Funding     |  |
| <input type="checkbox"/> Other _____     |   |  |  |

Provide the following information for all Primary/Contingent Owners and Beneficiaries: name; relationship to Proposed Insured(s); date of birth; social security/tax ID number; and address. Include E-Mail address. If Trust, provide Trustee Name and Date of Trust. Indicate additional: Owners; Contingent Owners; Primary Beneficiaries; and Contingent Beneficiaries in Supplemental Information section.

## 9. Owner/Contingent Owner Information

a) Identity of Owner: Proposed Insured #1 ☒ #2 ☐

Jean Lin *JS*  
 5/19/71 Spouse  
 128-64-5329

b) Identity of Contingent Owner (if applicable):

## 10. Beneficiary Information

Note: Multiple beneficiaries will receive equal proceeds unless otherwise requested by Owner.

a) Identity of Primary Beneficiary: ☐ Owner

Jean Lin  
 5/19/71 Spouse  
 128-64-5329

b) Identity of Contingent Beneficiary:

Chelsey Lin 50%  
 11/3/96  
 daughter  
 S.S.#: 626-92-1165  
 Angus Lin  
 11/9/95 50%  
 S.S.#: 604-86-5448  
 son

☐ Check here if all present and future natural or adopted children of Proposed Insured #1 are to be included as Contingent Beneficiaries.

## 11. Billing/Mailing Address:\*

☒ Proposed Insured #1 Residence Address:\*☐ Owner's Address (If not Owner listed in question 9a, indicate name and address below.)☐ Other Premium Payer (Indicate name and address below.)

(If Other, indicate relationship to Proposed Insured(s).)

☐ Proposed Insured #2 Residence Address☐ Primary Beneficiary's Address (If not Beneficiary listed in question 10a, indicate name and address below.)

Relationship

(Name:)

Address: Street

City/ State/ Zip)

\*If any other special mailing arrangements are needed, indicate in Supplemental Information section.



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12. Any person to be insured a dependent spouse or dependent minor? (If Yes, provide details below.) ☐ Yes ☒ No

a) Amount of insurance on spouse: Existing: \$ \_\_\_\_\_ Applied For: \$ \_\_\_\_\_

b) If dependent minor, are there any other siblings insured for less than this child? (If Yes, provide details in Supplemental Information section.) ☐ Yes ☒ No

c) Amount of existing and applied for insurance on parents of dependent minor:

Amount			Amount		
Father's Name	Existing	Applied For	Mother's Name	Existing	Applied For

**Part II**

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13. Within the past three years has any person to be insured flown in a plane other than as a passenger on a scheduled airline or have plans for such activity within the next year? (If Yes, complete Aviation Supplement.) ☐ Yes ☒ No

14. Within the past three years has any person to be insured participated in or intend to participate in any: underwater sports (SCUBA diving, hardhat, skin diving, snorkeling); sky sports (skydiving, hang gliding, parachuting, ballooning); racing sports (motorcycle, auto, motor boat); rock or mountain climbing; bungee jumping or other similar activities? (If Yes, complete Avocation Supplement.) ☐ Yes ☒ No

15. Are all persons to be insured U.S. citizens? (If No, provide details below including: country of citizenship; Visa/ID Card type; number; and expiration date.) ☒ Yes ☐ No

16. Has any person to be insured traveled or resided outside the U.S. or Canada in the past two years OR does any person to be insured intend to travel or reside outside the U.S. or Canada in the next 12 months? (If Yes, provide details below including: country; city; duration; and purpose.) ☐ Yes ☒ No

17. Has any person to be insured ever used tobacco products: (e.g. cigarettes; cigars; pipes; smokeless tobacco; chew) or nicotine substitutes: (e.g. patch or gum)? (If Yes, provide type, amount, date last used, and frequency below.) ☐ Yes ☒ No

18. Has any person to be insured: ever had a driver's license suspended or revoked; ever been convicted of DUI or DWI; or had any moving violations in the last five years? (If Yes, provide details below.) ☐ Yes ☒ No

Give details for question 15 through 18. Attach additional sheet(s), if necessary.

Proposed Insured	Question Number(s)	Date	Details

19. Attending Physician(s) of the Proposed Insured(s): (Provide: name; address; phone number; date; and reason for last consultation. Attach additional sheet(s), if necessary.)

Proposed Insured #1	
Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment
Dr. J. James Huang 740 W. Central Ave. #119 Brea, CA 92821 714-990-0325	8/04 Regular check up - Normal
Proposed Insured #2	
Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment



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20. Proposed Insured #1 Height: 5'6" Weight: 165 Proposed Insured #2 Height: \_\_\_\_\_ Weight: \_\_\_\_\_

21. Has any person proposed for insurance EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had:  
(Provide details for each Yes answer below.)

- a) High blood pressure; chest pain; heart attack; or any other disease or disorder of the heart or circulatory system? ☐ Yes ☒ No
- b) Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the respiratory system? ☐ Yes ☒ No
- c) Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Parkinson's; or any other disease or disorder of the brain or nervous system? ☐ Yes ☒ No
- d) Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of the liver, gallbladder, stomach, or intestines? ☐ Yes ☒ No
- e) Any disease or disorder of: the kidney; bladder; or prostate; or protein or blood in the urine? ☐ Yes ☒ No
- f) Diabetes; thyroid disorder; or any other endocrine disorders? ☐ Yes ☒ No
- g) Arthritis; gout; or disorder of the muscles, bones, or joints? ☐ Yes ☒ No
- h) Cancer; tumor; polyp; cyst; anemia; leukemia; or any other disorder of the blood or lymph glands? ☐ Yes ☒ No
- i) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms? ☐ Yes ☒ No

22. Has any person proposed for insurance: (Provide details for each Yes answer below.)

- a) In the past six months, taken any medication or been under observation or treatment? ☐ Yes ☒ No
- b) Scheduled any: doctor's visits; medical care; or surgery for the next six months? ☐ Yes ☒ No
- c) During the past five years had any: checkup; health condition; or hospitalization not revealed above? ☐ Yes ☒ No
- d) Ever been diagnosed with, treated by a medical professional for, or tested positive during a medical examination for life insurance for; any of the following: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); AIDS (Human Immunodeficiency Virus (HIV)) virus; or antibodies to the AIDS (HIV) virus? ☐ Yes ☒ No
- e) Ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner? ☐ Yes ☒ No
- f) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem? ☐ Yes ☒ No

23. Answer Question 23 only when requesting the Long-Term Care Guaranteed Purchase Option.

(Provide details for each Yes answer below.)

- a) Do you currently use any mechanical equipment i.e.: a walker; wheelchair; leg braces; or crutches? ☐ Yes ☐ No
- b) Do you need any assistance; or supervision with the following activities bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence; or taking medication? ☐ Yes ☐ No

Give details of each Yes answer from Questions 21, 22, and 23. Attach additional sheet(s), if necessary.

Proposed Insured	Question Number	Name/Address of Physician	Date/Duration Illness	Diagnosis/Severity/Treatment



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**AGREEMENT/DISCLOSURE**

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- My acceptance of any insurance policy means I agree to any changes shown in the Home Office Endorsements section, where state law permits Home Office endorsements.
- This application and any: amendment(s); paramedical/medical exam; and supplement(s) that become part of the application, will be attached to and become part of the new policy.
- Only the Company's President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- No information will be deemed to have been given to the Company unless it is stated in this application and its supplement(s), paramedical/medical exam, and amendment(s).
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I intend to replace existing insurance or annuities, I have so indicated in question 4 of this application.
- I have received the Company's Consumer Privacy Notice and, as required, the Life Insurance Buyer's Guide.
- If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.

**Substitute Form W-9 – Request for Taxpayer Identification Number**

Under penalties of perjury, I, Jean Lin (Owner's Name), 128-64-5329 (Owner's Taxpayer ID #), certify:

- 1) That the number shown above is my correct taxpayer identification number; and
- 2) That I am not subject to backup withholding because: (a) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding; and
- 3) I am a U.S. citizen or a U.S. resident for tax purposes.\*

Please note: Cross out and initial item 2 if subject to backup withholding as a result of a failure to report all interest and dividend income. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications to avoid backup withholding.

\*If you are not a U.S. citizen or a U.S. resident for tax purposes, please complete form W-8BEN.

**Signatures:**

	Signed at City, State	Mo./Day/Yr.	Signature
<b>Owner*</b> (age 15 or over) (If other than a Proposed Insured)	<u>Irvine, CA</u>	<u>8/5/04</u>	<u>[Signature]</u>
<b>Proposed Insured #1</b> (age 15 or over)	<u>Irvine, CA</u>	<u>8/5/04</u>	<u>[Signature]</u>
<b>Proposed Insured #2</b> (age 15 or over)			<u>X</u>
<b>Parent or Guardian or person liable for child's support</b>			<u>X</u>
(Signature required if Owner or Proposed Insured(s) is/are under the age of 18 and the Parent, Guardian or person liable for the child's support has not signed above.)			
<b>Witness to Signatures</b> (Licensed Agent/Producer)	<u>Irvine, CA</u>	<u>8/5/04</u>	<u>X [Signature]</u>

\*If the Owner is a Firm or Corporation, include Officer's Title with signature. (Officer signing must be other than a Proposed Insured.)



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FAX NO. 19082033822

P. 02/21

**PART II: Paramedical/Medical Exam**

- ☒ Metropolitan Life Insurance Company  
☐ MetLife Investors Insurance Company of California  
☐ New England Life Insurance Company  
☐ Texas Life Insurance Company

Case/Policy No.: 204126486

- ☐ Metropolitan Tower Life Insurance Company  
☐ Metropolitan Insurance and Annuity Company  
☐ MetLife Investors USA Insurance Company  
☐ General American Life Insurance Company

The Company indicated above is referred to as "the Company".

For Texas Life: If medical examination is not required, questions are to be completed by Agent.

The spaces below are for answers of person to be examined only. Nothing but the answers of such person should be recorded.

1. Name of Proposed Insured: (Last, First, Middle) <u>LIN. BANG. C</u>	Date of Birth: (Mo./Day/Year) <u>08-06-1969</u>
2. Tobacco Use - Indicate date last smoked/used: <input checked="" type="checkbox"/> Never <input type="checkbox"/> Cigarette <input type="checkbox"/> Smokeless Tobacco <input type="checkbox"/> Cigar/Pipe <input type="checkbox"/> Patch/Gum Amount/Frequency: _____ Tobacco Never Used: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3. Who is the doctor, practitioner, or health care facility who can give us the most complete and up to date information concerning your present health? If "None", check <input type="checkbox"/> . Name, full address, and phone number: <u>Dr. JAMES HUANG (714) 980-0376</u> <u>340 WEST CENTRAL AVE #119, BREA, CA 92821</u> When was this doctor last consulted? <u>08/2004</u> Why? <u>skin itching</u> What treatment was given or medication prescribed? If "None", check <input checked="" type="checkbox"/> Reasons, findings, earlier consultations past 5 years? <u>WNL</u>	
4. a) Height <u>5 ft. 8 in.</u> b) Weight <u>170 lbs.</u> c) Change in weight in past 12 months (give reason) Pounds lost <u>0</u> Pounds gained <u>0</u> Reason <u>0</u>	
5. Have you EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that you had: Details: List question number. Give details; dates; duration; diagnosis; treatment; and doctors' names and addresses.	
a) High blood pressure; chest pain, heart attack; or any other disease or disorder of the heart or circulatory system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b) Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c) Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Lou Gehrig's disease (ALS); memory loss; Parkinson's disease; progressive neurological disorder; headaches; dizziness; or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
d) Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of the liver, gallbladder, stomach; or intestines?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
e) Any disease or disorder of the kidney; bladder; prostate; reproductive organs; or breasts; sexually transmitted disease; sugar; albumin; blood or pus in the urine?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
f) Diabetes; thyroid disorder; or any other endocrine disorder?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
g) Arthritis; gout; or disorder of the muscles, bones, or joints?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
h) Cancer; tumor; polyp; or cyst? Any disease or disorder of the skin?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

AUG-30-2004 MON 01:37 PM bridgewater

FAX NO. 19082033822

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Details (Continued):

1) Anemia; leukemia; or any other disorder of the blood or lymph glands? ☐ Yes ☒ No

2) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms? ☐ Yes ☒ No

3) Any disease or disorder of the eyes, ears, nose, or throat? ☐ Yes ☒ No

6. Are you now, or within the last six months, under observation or taking medication or treatment? (Including over the counter medications, vitamins, herbal supplements, etc.) ☐ Yes ☒ No

7. Do you have any doctor's visits, medical care, or surgery scheduled? ☐ Yes ☒ No

8. Other than the above, during the past five years have you had any:

a) Checkup; electrocardiogram; chest x-ray; or medical test? ☐ Yes ☒ No

b) Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication? ☐ Yes ☒ No

9. Have you:

a) ever been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)? ☐ Yes ☒ No

b) ever tested positive during a medical examination for life insurance for the AIDS (HIV) virus or for antibodies to the AIDS (HIV) virus? ☐ Yes ☒ No

10. a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner? ☐ Yes ☒ No

b) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem? ☐ Yes ☒ No

11. Do you exercise? ☒ Yes ☐ No Type: SWIMMING / GOLF How often? 2 times/wk 1-3 hrs

12. Are you now pregnant? ☒ Yes ☐ No If "Yes", estimated date of delivery? \_\_\_\_\_

13. Has a parent or sibling of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; cancer; diabetes; or mental illness? (If Yes, indicate below.) ☐ Yes ☒ No

Relationship to Proposed Insured:	Age(s) if Living:	Age(s) at Death:	State of Health (Specific Conditions) or Cause of Death. Attach additional sheet(s) if necessary.

14. a) Do you currently use any mechanical equipment such as a walker, wheelchair, long leg braces or crutches? ☐ Yes ☒ No

b) Do you need any assistance or supervision with the following activities: bathing, dressing, walking, moving in/out of a chair or bed, toileting, continence or taking medication? ☐ Yes ☒ No

I have read the answers to questions 2-14 before signing. They have been correctly written, as given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

Witness to Signature	City and State	Mo./Day/Year	Signature of Proposed Insured (Parent or Guardian if under 18)
<u>[Signature]</u>	<u>IRVINE, CA</u>	<u>08/18/04</u>	<u>[Signature]</u>

Citron Pethky



AUG-30-2004 MON 01:38 PM bridgewater

FAX NO. 19082033822

P. 64/21

**Report of Paramedical/Medical Examiner**

- Complete Sections I and III for Paramedical Exam
- Complete Sections I, II and III for Physician's Exam

**Section I**

1. (a) Date of birth 08-26-67 (b) Sex M ☒ F ☐ (c) If female, was proposed insured menstruating on date of this examination? Yes ☒ No ☐
2. Height (in shoes) 5 ft 8 in. Weight (clothed) 170 lbs. Chest (full inspiration) 38 in. Chest (forced expiration) 36 in. Abdomen (at umbilicus) 33 in.
- Did you measure? Yes ☒ No ☐ Did you weigh? Yes ☒ No ☐
3. Blood Pressure (Record ALL readings - at least two):
- | Sitting                          | 5th phase | If systolic over 140 or diastolic over 90, repeat later in exam |
|----------------------------------|-----------|---|
| Systolic/Diastolic <u>114/74</u> | <u>74</u> | <u>120/76</u>   |
4. Pulse At Rest: Rate (per min.) 76 Irregularities (per min.) 0
5. Is appearance unhealthy or older than stated age? Yes ☐ No ☒
6. Urinalysis: Protein: Positive ☐ Negative ☒ Sugar: Positive ☐ Negative ☒  
Is blood also being sent to lab? Yes ☐ No ☒ ECG done? Yes ☐ No ☒

for analysis  
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Details for answers to questions 7-11.

**Section II****7. Heart: Is there any:**

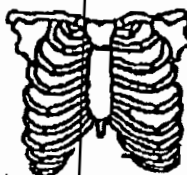
- a) Enlargement? Yes ☐ No ☒ c) Dyspnea? Yes ☐ No ☒  
b) Murmur(s)? Yes ☐ No ☒ d) Edema? Yes ☐ No ☒  
(If Yes, complete below)

Murmur 1 Murmur 2

Location (Apical, Aortic, Pulmonic, Parasternal)  
Timing (Systolic, Presystolic, Diastolic)  
Quality (Sparse, Blowing, Rumbling, Musical)  
Loudness (Grade 1-6)  
Constant (Yes or No)  
Transmitted (Yes or No)  
After Exercise (Increased, Absent, Unchanged, Decreased)

**Indicate:**

Apex by: X  
Murmur area by: 0  
Point of greatest intensity by: 0  
Transmission by: 0

**8. Is there on examination any abnormality of the following?**

- a) Eyes, ears, nose, mouth pharynx? (If vision or hearing markedly impaired, indicate degree and correction) ☐ Yes ☒ No
- b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries? ☐ Yes ☒ No
- c) Nervous system (include reflexes, gait, and paralysis)? ☐ Yes ☒ No
- d) Respiratory system? ☐ Yes ☒ No
- e) Abdomen (describe scars, liver enlargement)? ☐ Yes ☒ No
- f) Genitourinary system? ☐ Yes ☒ No
- g) Endocrine system (include thyroid)? ☐ Yes ☒ No
- h) Musculoskeletal system (include spine, joints, amputations, and deformities)? ☐ Yes ☒ No
9. Are there any hemias? ☐ Yes ☒ No
10. Are you aware of additional medical history? ☐ Yes ☒ No
11. Are you the personal physician of the applicant? ☐ Yes ☒ No
12. Please provide your overall clinical impression of proposed insured:

**Section III Name of person examined**Date/Time of exam 10-00Place of exam: ☐ Examiner's office ☐ Proposed insured's Residence ☒ Proposed insured's BusinessCity/State IRVINE, CA APPS #09Agent/Broker Judy Lou Branch/District # or Agency 12325Signature of Paramedical/Medical Examiner C. Lou Los Angeles, CA 90010Printed Name C. Lou Address 12325 Tel: 210-689-2777

Fax: 112298722